AHIP Detailed Comments on
Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter

CY 2014 ADVANCE NOTICE

Attachment I. Preliminary Estimate of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2014 (pages 5 – 7)

- **Medicare Physician Fee Schedule Update**. As in previous years, the Office of the Actuary (OACT) has indicated on recent CMS and OACT conference calls that the MA and FFS growth rates assume implementation of the minus 30 percent physician fee schedule update for CY 2014 that is required under the statutory SGR formula. This decision is inconsistent with anticipated Congressional action to negate the physician fee reduction, action that the Congress has taken every year since 2003. However, CMS has indicated that this practice is statutorily required. As in past years, we strongly disagree with this interpretation, and in light of the magnitude of the negative payment trend estimated for MA organizations for CY 2014, in addition to the continued phase-in of the Affordable Care Act (ACA) payment methodology and other factors, it is even more important this year for CMS to reconsider its position.

  The statute does not specify the manner in which the estimates of per capita MA and FFS costs must be developed and does not compel reliance on current law, particularly when there is every reason to expect that the law will be overridden. In fact, there is a sound basis for interpreting the statute to support CMS' development of estimates in a manner that would produce the most accurate prediction of future costs. CMS has interpreted the Social Security Act (Section 1853(c)(6), National Per Capita MA Growth Percentage) to require the agency to calculate MA rates based upon current law, because it references the growth percentage "for a year" for expenditures required "under this title" (Title XVIII). However, an analysis of this section and a closely related provision (Section 1876(a)(4)) also clearly supports an alternative interpretation. Section 1853(c)(6) can reasonably be read to refer to the types of expenditures (e.g., covered services) authorized under Title XVIII for a year rather than the manner in which costs must be determined, and Section 1876(a)(4) requires estimates "on the basis of actual experience, or retrospective actuarial equivalent…with adjustments to ensure actuarial equivalence." While these provisions do not compel CMS to take into account foreseeable future events that impact growth rate estimates, they would permit CMS to exercise the discretion to utilize information that would provide the most reliable estimates of the MA and FFS growth percentages.

  This reading would provide authority for CMS to take into consideration the expected action by the Congress to provide relief from the physician fee schedule

reduction, as it has in the past, and support an assumption of a 0 percent update to avoid inappropriately subjecting MA plans to a reduction in rates. Such an approach would align the MA payment methodology with the guidance OACT has provided to MA organizations in the past, which has required them to assume for bidding purposes that Congress negates the physician fee reduction in order to ensure that they are utilizing the most reliable estimates in their bids. The statutory provisions governing the establishment of the Part B premium also provide a framework that has permitted CMS to take the expected level of physician fees into consideration in estimating program costs.

- **Summary of Key Projections/Assumptions -- Transparency**. On an annual basis, CMS issues preliminary estimates of the National Per Capita Medicare Advantage Growth Percentage, or MA growth rate, and the Fee-for-Service (FFS) United States Per Capita Cost (USPCC), or FFS growth percentage, and on page 7 of the Advance Notice the agency indicates that further details on the derivation of these growth percentages for 2014 will be presented in the final rate announcement that will be issued on April 1, 2013. The predictability of trends in rates and payments is critical to sound bid development and the multi-year planning that makes sustained MA program participation possible for health plans and supports continuity of coverage and stability of benefits for MA enrollees. Transparency about the data and assumptions underlying the growth rates is essential to the reliability of the estimates developed by MA organizations for this purpose, and as in past years, we strongly urge CMS to make available to MA organizations more detailed information to permit them to replicate the agency's preliminary growth rates, as well as the growth rates CMS utilizes for the final MA rate announcement.

  While we recognize that CMS has provided a high-level description of the underlying factors that explain the preliminary growth rate during recent conference calls, this information is not sufficient. The importance of releasing additional, more detailed information has been heightened this year by the significantly larger negative trend in both the MA growth percentage and the FFS growth percentage than MA organizations across the country have anticipated. Bid development has already been underway for some time, as well as related efforts by MA organizations to update their projections of cost trends that impact rates for CY 2014 and future years. Significant, unanticipated negative growth rate estimates of the magnitude reflected in the Advance Notice, including negative updates to prior year estimates, have serious implications for MA organizations committed to serving their enrollees through long term program participation and understanding the basis for these estimates is critical. We strongly recommend that CMS provide additional information by March 8 to permit MA organizations to utilize it in the near term. We also recommend that the agency release detailed information in future years to accompany the Advance Notice as well as the final rate notice. Further, we recommend that CMS consider interim data releases and analyses, notification of the release of other relevant

sources of data, and related analyses that would provide MA organizations with greater insight into emerging MA and FFS cost trends.

We ask that the following data be provided as part of this request:

+ Detailed data and explanation of causes for revisions of prior year trends, including recent utilization trends compared to historical utilization patterns.

+ Recent medical service utilization, unit cost, and severity patterns in the Medicare program compared with historical data, and analysis of causes for changes in such patterns, including attribution to specific provisions in the Affordable Care Act or other legislation, Agency financial management initiatives, and macroeconomic effects.

+ Detailed documentation of the projection methodology for 2013 and 2014 trends, including sources of data referenced and explicit assumptions about which, if any, of the causes of revisions of 2011 and 2012 are expected to continue, including the impact of physician fee schedule updates, utilization changes, and population demographics, and detailed calculations leading to determination of the minus 1.1% trend impact in 2014 from the American Taxpayer Relief Act (ATRA) of 2012 that was cited on recent CMS calls.

+ Sufficient detail to evaluate changes in FFS Medicare costs and trend rates for years going back to 2008 which would include information for payments made after the cut-off dates that is not available through existing sources (e.g., the 5% and 100% LDS files).

+ The Agency's estimates of payments to Medicare Advantage organizations in 2012, 2013, and 2014, and assumptions about MA plan enrollment as it relates to those estimates.

+ The manner by which the Agency estimated the effect of recent court decisions involving the Agency, including the impact of Medicare Improvement Standard settlement (Jimmo vs. Sebelius) on both the restatement periods as well as the future trend projections and the extent to which the estimated impact of these decisions on the cost and utilization of medical services are reflected in the revised trend estimates.

Attachment II. Changes in the Part C Payment Methodology for CY 2014

Section F. Calculation of Fee for Service Rates (page 13)

- **Changes to AGA Methodology.** For 2014, CMS is proposing to revise the calculation of the average geographic adjustment (AGA), which is the county-level geographic index utilized in determining the Fee-for-Service (FFS) cost for each county that is used in determining MA benchmarks under the ACA payment methodology. Specifically, CMS is considering a new third step in the AGA calculation to adjust the historical data to reflect more current FFS pricing rules. CMS states this modification may have disparate geographic impacts and will represent a significant change from the existing methodology. However, the agency indicated on recent conference calls that it has not yet completed analysis of these impacts, and MA organizations are experiencing challenges performing their own analyses within the brief period available for comment on the Advance Notice. We recommend that CMS make its evaluation of the impact of the proposed change available to MA organizations as quickly as possible. Further, in light of the limited time available for MA organizations to assess the proposal's implications and the variation in geographic impacts that CMS has cited, we recommend that CMS ensure that MA organizations will not be adversely impacted by establishing a limit on the magnitude of any negative changes to benchmarks that would be implemented in 2014 as a result of this change in methodology.

Section G. Recalibration and Clinical Update of the CMS-HCC Risk Adjustment Model (page 16)

- **Updated Aged/Disabled CMS-HCC risk adjustment model.** The Advance Notice proposes that in 2014 CMS will implement an updated version of the aged/disabled CMS-HCC risk adjustment model for beneficiaries enrolled in MA organizations and PACE organizations. The agency explains that CMS has used more recent data years to recalibrate the model and that the new model will reflect a clinical update that will involve a variety of changes including adding, consolidating, splitting, and eliminating HCCs, and altering the treatment of disease interactions. The agency's analysis of the impact of the revised risk adjustment model indicates that the average risk scores for MA contracts would be lower than under the 2013 model. CMS states that this is because the HCCs that experience reductions in their relative value under the revised model are those that MA organizations tend to code at higher rates than FFS providers. The agency is initiating a multi-year phase-in of the new model and is initially applying an adjustment designed to ensure that the average MA risk score for 2014 would approximate the average risk score for 2013.

  The proposed changes to the risk adjustment model raise a number of serious concerns. First, by focusing risk adjustment changes on diagnoses that are

reported at higher rates by MA organizations than by FFS providers, these changes penalize beneficiaries who benefit from disease and care management programs targeted to address their needs and plan efforts to identify the diagnoses important to their care. Beneficiaries enrolled in MA plans that disproportionately serve individuals with complex health care needs could be more severely impacted, which is inconsistent with Medicare program goals for better care coordination for those with the highest needs. Second, while we appreciate that CMS is proposing a phase-in to mitigate the impact of the changes to the model, we are concerned that CMS may not have sufficient data to reliably estimate the implications of the model. In the past, when CMS has added diagnoses the agency has faced challenges obtaining data that is sufficiently complete and broadly representative, because all plans do not submit diagnoses beyond those in the existing model. CMS should work with MA organizations to ensure that impact estimates provide accurate insight prior to implementation. Third, although the agency has established an adjustment intended to maintain a consistent average MA risk score for 2013 and 2014, initial estimates by MA organizations suggest that the adjustment is not adequate to meet this goal, possibly for the data reasons cited above. For these reasons, we strongly recommend that CMS delay implementing the proposed changes to the risk adjustment model, rather than phasing them in as proposed. The agency should reconsider these changes and consult with MA organization risk adjustment experts as it pursues further evaluation of the implications of such modifications to the model.

Section H. Medicare Advantage (MA) Enrollee Risk Assessments (page 22)

- **Health Risk Assessments.** The Advance Notice indicates that beginning with 2013 dates of services, CMS will require MA organizations to flag diagnoses collected in enrollee risk assessments in an effort to "ensure that payments to MA organizations are accurate, that treatment for identified conditions is done when appropriate, and that costs are reflective of treatment." The agency also will be considering different approaches for ensuring the accuracy and completeness of risk assessment information. In addition, the notice states that for payment year 2015, CMS is considering excluding for risk adjustment payment purposes the diagnosis data collected from MA enrollee risk assessments that are not confirmed by a subsequent clinical encounter by a provider type that has been approved for risk adjustment purposes.

  Under the ACA (at section 1861(hhh)(1)(A)) these assessments must be offered during the annual wellness visit, and under the MA regulations (at §422.112(b)(4)(i)) they must be offered to new MA enrollees to ensure continuity of care and integration of services. CMS acknowledges that a health risk assessment (HRA) is clinically valuable to assess beneficiary health, make diagnoses, and identify gaps in care. As CMS notes, in addition to health risk assessments that may be conducted in a physician's office, MA organizations may arrange to provide health assessments in a beneficiary's home, and we understand

they may also take place in other settings convenient for the enrollee. Regardless of the setting, when assessments are conducted face-to-face by medical professionals, including physicians, physician's assistants, nurse practitioners, and advanced practice nurses, it is our understanding that the results can currently be included in the patient's medical record, and diagnoses may be reported for risk adjustment.

We believe that such diagnoses should continue to be reportable for this purpose for several reasons. CMS has placed an emphasis on the medical record as the foundation for validating diagnoses for risk adjustment and disallowing certain diagnoses that are properly supported in the record appears to be fundamentally at odds with this approach. Further, the challenge of encouraging physicians to document chronic conditions year after year in beneficiary medical records has been the focus of numerous discussions with the agency over an extended period based upon an understanding that the presence of such conditions in the data collection year is a relevant predictor of health status and the costs of care in the subsequent payment year. CMS' proposal appears to signal a re-evaluation of its policies in the fundamental areas of medical record documentation and the role of chronic conditions in the risk adjustment model. We strongly disagree with the conclusions reflected in the draft Call Letter, urge CMS to reconsider its proposal, and recommend that the agency engage in discussions with MA organization risk adjustment experts to inform this effort. If CMS has concerns that some health risk assessments are not sufficiently thorough, we recommend that the agency consider developing criteria for such assessment that addresses this issue rather than potentially disallowing all diagnoses collected through these efforts.

Finally, we note that the strategies employed by MA organizations to address diagnoses identified in health risk assessments extend well beyond treatment that may be provided in a physician visit. Disease and care management programs for beneficiaries, education programs for beneficiary self-care, counseling, and other outreach and programs are targeted to beneficiaries based upon their diagnoses and identifying gaps in care is an important goal of these assessments for MA enrollees as well as for beneficiaries in FFS Medicare. While such activities may not be documented in a subsequent medical record, they nevertheless represent costs for services that are valued by beneficiaries as well as clinically significant and relevant to the risk adjustment model. We urge CMS to include this issue, as well, in its further consideration of the collection of data from health risk assessments for risk adjustment purposes.

Attachment VI. CMS Draft CY 2014 Call Letter

Section I – Parts C and D

Star Ratings Changes (pages 89-105)

Changes to the Methodology of Current Measures (page 89)

- **Quality Improvement (Part C and D).** CMS is proposing to modify the hold harmless provision for contracts with overall ratings of 4 stars or more by providing that if a contract receives 5 stars on a measure for both years evaluated for the improvement measure, the contract will be held harmless regardless of whether the data for the measure declined in the second year. It is unclear how CMS' proposed changes to the calculation of the overall Star Ratings interact with the proposed change to the hold harmless provision, and if the agency moves forward with revision of the calculation, we recommend that CMS clarify this issue.

- **High-Risk Medication Use (Part D).** CMS is proposing that the updated PQA High Risk Medication (HRM) list be applied to calculate the HRM measure for the 2015 Star Ratings using 2013 PDE data, which is a change from the agency's previous proposal that would have required use of the list in determination of the 2014 Star Ratings. We support the agency's proposal to delay applicability of the updated PQA list, in order to provide plans with additional time to take actions necessary to comply, for example by modifying their strategies for promoting compliant drug regimens and revising beneficiary educational materials as needed. As we commented previously, AHIP continues to urge CMS to ensure that the criteria are not applied in a manner that is inappropriately restrictive through use of the HRM measure in the Star Ratings and encourage the agency to evaluate the potential for adverse consequences for ratings when clinical decisions that are in the best interest of individual beneficiaries are not aligned with the criteria. As we previously indicated, according to a recent article in the Journal of the American Geriatrics Society, the 2012 Beers Criteria Update Expert Panel has emphasized that while the criteria are important, "the Beers criteria should not substitute for professional judgment or dictate prescribing for an individual patient" because principles that call for tailoring care for an individual patient are paramount.[1]

  We also note that CMS is proposing to clarify the technical notes for this measure to specify that the measure calculates the percentage of Medicare Part D beneficiaries 65 years or older who received two or more prescription fills for "the same HRM drug" with a high risk of serious side effects. We support CMS' clarification to promote consistent understanding of the measure specifications.

Changes in the Calculation of the Overall Rating (Pages 94-95)

- **Star Ratings: Changes in the Calculation of the Overall Rating and the Part C and D Summary Ratings (page 94).** Beginning with the 2014 Star Ratings, CMS is proposing to calculate overall and summary star ratings by using the individual measure scores (e.g., percent, rate or score) instead of the star rating

[1] Barbara Resnick, PhD, CRNP, FAAN, and James T. Pacala, MD, MS, AGSF, *2012 Beers Criteria,* Journal of the American Geriatrics Society, 60, no. 4 (April, 2012) 612

that corresponds to the measure score. The agency notes that this change is meant to address the risk of "misclassifying" a contract if the Star Ratings "do not reflect a contract's 'true' performance" because measure scores "are more precise reflections of the performance data than the measures' star ratings".

AHIP has serious concerns with the new methodology because initial MA organization evaluations indicate that the proposed changes could result in material shifts in the ratings. For example, some contracts that would otherwise meet established 4-star thresholds would become 3-star plans. The resulting loss of quality bonuses in 2015 could inappropriately impact benefits and premiums for beneficiaries in these highly rated plans. Although details of the methodology are unclear, including for example, how the i-Factor might be impacted, it is our understanding that the new methodology would rely upon plan performance in relation to outliers on both on the low and high end as anchor points to rescale plan performance on each individual measure. To the extent that the performance of an outlier is significantly lower than other plans, the rescaled scores of all contracts will be affected. This is more likely starting in 2015 when CMS will include low-enrollment contracts in the star ratings system, because of the instability injected into the overall and summary ratings calculations due to the volatility inherent in small numbers. The new methodology, therefore, could reduce the opportunity for MA organizations to earn or retain high ratings to qualify for quality bonuses that will benefit their enrollees. This result would be inconsistent with the goal of the Affordable Care Act to promote high performance across the Medicare Advantage and Part D programs.

While we have identified these serious initial concerns, MA organizations need more detailed information beyond the examples and technical description CMS has provided to assess fully its implications. We strongly recommend that CMS not implement the proposed change to the calculation of CY 2014 overall star ratings for MA and Part D contracts and issue a more detailed technical description of the proposed methodology along with the agency's evaluation of its anticipated impact and provide a further comment opportunity of no less than 30 days to allow time for MA organizations to assess the proposal.

Low Performer Icon (Page 96)

CMS is proposing to assign the Low Performer Icon (LPI) to any MA-PD contract that receives 2.5 stars or lower for any combination of MA or Part D summary ratings for three consecutive years. The agency currently assigns the LPI to contracts receiving less than 3 stars for Part C or Part D summary ratings for the last 3 consecutive years. AHIP does not support this proposed change. We believe that the agency's current policy of assigning the LPI individually for Part C and Part D performance is a more appropriate approach given the differing plan activities and processes related to providing medical benefits under Part C in contrast to providing prescription drug benefits under Part D. We believe it is important for organizations to be afforded the full three years under the agency's

policy to improve low performance under each program before being assessed for the LPI, and it is not clear that this will continue to be the case if CMS moves forward with the proposed change. We recommend that CMS maintain the current policy and not move forward with the proposed change.

We also note that the explanatory language that currently appears on the Medicare Plan Finder (MPF) website regarding the LPI is potentially misleading. Specifically, the LPI and a related note that cautions beneficiaries that the plan is low rated appear under the column labeled "Overall Plan Rating" which implies that the LPI is an indicator of a plan's overall plan rating, rather than an indicator of performance under Part C and/or Part D more specifically. For clarity, we recommend that CMS reevaluate and revise the explanatory language for the 2013 LPI on the MPF accordingly.

Integrity of Star Ratings (Page 99)

- **Reduction in Star Ratings for data issues.** CMS indicates that the agency's policy is to reduce a contract's measure rating to 1 star if "it is identified that biased or erroneous data have been submitted by the plan or identified by CMS." The agency has provided a brief description of the types of cases that would fall into this category along with several examples. While we recognize the importance of ensuring that data provided by plans are reliable and accurate, including for the purposes of calculating Star Ratings, we do not support the agency's policy of reducing a contract's rating as noted above for the reasons outlined in the draft. Specifically, we believe that such a policy should only be applied in instances where CMS has identified egregious and systemic submission of biased or erroneous data. We recommend that CMS review and revise the current policy accordingly.

Disaster Implications (Page 99)

- **Impact of Hurricane Sandy.** CMS is requesting that plans that have experienced a problem as a result of Hurricane Sandy and have not yet contracted CMS, should do so by February 28, 2013. As we previously stated, AHIP believes CMS has taken important steps in working with affected organizations to identify short and longer-term impacts on their participation in the MA and Part D programs resulting from Hurricane Sandy (e.g., impacts on timely data reporting, complaint rates, timely claims processing, and provider operations), and we appreciate the agency's establishment of avenues to maintain close communication with these organizations. However, it is our understanding that in some instances, plans may not be able to determine the full impact of Hurricane Sandy on their operations until they are able to fully assess the full range of data for the 4th quarter of 2012 (e.g., claims and other data), which due the time frame for receipt of some of the data may not occur until after the February 28 deadline (e.g. late April 2013). As a result, we recommend that CMS consider extending the deadline to accommodate these circumstances. We also recommend that CMS

consider establishing a permanent process going forward to address the impact of disasters in the future.

Section II – Part C

Supplemental Benefits Guidance (page 111)

- **Pap Smear/Pelvic Exams.** CMS indicates that for CY 2014, MA plans will be required to adhere to the Medicare Part B benefits schedule for providing $0 cost share preventive services and will not be able to offer annual screening Pap smears/pelvic exams as supplemental benefits. We note that employer/union group health plans offering MA plans to their retirees may seek to offer MA plan benefits that correspond to health benefits offered to non-retiree employer group health plan participants, in some cases as a result of union contracts. Lack of flexibility to design MA plan benefits in this way has been a barrier to the offering of MA plans by employer/union group health plans in the past and preserving the ability of MA organizations to design benefits to meet employer/union group health plan preferences is important to the continued availability of MA plans to employer group health plan retirees. Accordingly, we recommend that CMS signal the agency's willingness to establish an employer group waiver excepting MA plans offered through employer/union group health plans from the proposed requirement.

Rewards and Incentives Programs for Medicare Advantage Organizations (page 112**)**

- **Rewards and Incentives.** CMS is considering how the agency's existing rewards and incentives policy and guidelines for MA organizations may be expanded further to promote innovative programs to improve health outcomes and lower costs and is soliciting information from plans to help inform its decision making. AHIP member organizations have a strong interest in exploring these opportunities, and we commend CMS for inviting feedback on these important topics. However, the current brief comment period does not offer sufficient opportunity to prepare relevant information for submission due to the number and scope of issues addressed by the Advance Notice and draft Call Letter and we recommend that CMS provide a separate, longer comment period (e.g., 60 days) for organizations to share the requested information. We encourage CMS to pursue these issues and look forward to commenting in the near future. We note that CMS has included a similar request for information under Section III of the Call Letter for Part D plan sponsors, and we have reiterated there our member organizations' interest in providing feedback.

Meaningful Difference (Duplicative Plan Offerings) (page 115**)**

- **HMO and HMO-POS Plans.** The draft Call Letter indicates that although CMS currently considers HMO and HMO-POS plans separate plan types for the agency's meaningful difference evaluation, going forward, CMS is proposing to combine HMOs and HMO-POS plans into one plan type. According to CMS, the agency's analysis shows that not all HMO-POS plans offer all Parts A and B benefits on an out-of-network basis without limitations, and therefore, CMS believes that a reasonable business case can be made that these plan types are very similar. CMS states that the agency intends to look more closely at these plans in 2014. AHIP recommends that CMS maintain HMO and HMO-POS as two separate plan types. We understand that MA organization experience with these offerings is that beneficiaries regard them as clearly distinguishable and make informed decisions about the plan type they select. We would welcome the opportunity to arrange for member organizations to meet with you to provide more detailed information about their experience.

Total Beneficiary Cost (TBC) (page 117**)**

- **TBC Amount.** The draft Call Letter indicates that for CY 2014 bids, the agency is proposing to reduce the allowed Total Beneficiary Cost (TBC) change amount from $36.00 per member per month (PMPM) to $30.00 PMPM. AHIP does not support the proposed change. CMS should not place greater constraints on permissible adjustments to MA plan benefits and premiums for CY 2014 than in CY 2013 when MA organizations could experience estimated reductions in payments of nearly 8 percent in 2014. We are concerned that the more stringent standard has the potential to make it more difficult for plans to remain in some geographic areas where beneficiaries rely on them and threaten beneficiary access to the disease management, care coordination, and other plan programs and services that they value. The lower TBC standard can be expected to severely challenge MA organizations as they work to meet CMS bid guidance that requires them to demonstrate a positive financial condition on the one hand, while on the other the TBC requirement forces them to consider benefit and premium options that they cannot afford. In some cases, it simply may not be possible for organizations to meet both standards forcing difficult decisions for both enrollees and MA organizations. AHIP recommends that at a minimum, CMS retain the CY 2013 TBC change amount of $36 for CY 2014 rather than reducing it to $30 as proposed to avoid heightening the potential for adverse consequences for MA enrollees.

Medicare Advantage Part C EOB (page 124**)**

- **Part C EOB.** The draft Call Letter states that CMS expects to require use of the model Part C EOB by October 2, 2013 and that the agency is currently reviewing comments that were submitted in response to the November 2012 comment opportunity on this initiative and the subsequent Paperwork Reduction Act (PRA)

notice. As we have stated in our previous comments on this topic, AHIP shares CMS' interest in pursuing, on an ongoing basis, opportunities for providing beneficiaries with additional information that permits them to make the best use of their Medicare health plans and benefits. However, we continue to strongly believe that given the significant concerns we have identified about the length and complexity of the draft model Part C EOB for beneficiaries and the scope of the operational challenges we have previously raised, including unique challenges for organizations with capitated provider arrangements, a longer implementation timeline will be critical. For example, we believe that there are significant issues related to the clarity and utility of the proposed model for beneficiaries that warrant further consideration. In addition, MA organizations need sufficient time following issuance of the final model to develop or modify systems and to conduct testing to produce the new EOBs.

We also continue to urge CMS to take into consideration that MA organizations are currently engaging in other major systems modifications and development in order to implement, for example, MA encounter data reporting and ICD-10. These major initiatives depend heavily upon the same systems resources necessary to carry out development and implementation of the Part C EOB. Accordingly, we reiterate our recommendation that CMS defer implementation of the Part C EOB until January 2015, to ensure that design issues that are likely to impact ease of use of the EOB for beneficiaries can be evaluated and addressed and MA organizations are afforded the time necessary for orderly planning, appropriate resource allocation and extensive systems development.

Summary of Benefits (SB) Update (page 124**)**

- **Summary of Benefits.** The draft Call Letter states that CMS is considering significant revisions to the structure and format of the Summary of Benefits (SB) based on feedback from plans and consumer testing. The agency has identified two areas that would be the focus of the revisions and is soliciting comments from MA organizations in an effort to assist CMS in creating an SB that is a more beneficiary friendly and useful document. We strongly support this CMS initiative to improve the SB for beneficiaries and are interested in providing comments to contribute to this effort. However, the short period for commenting on the Advance Notice and draft Call Letter does not provide sufficient time to develop the thoughtful feedback this project warrants. We recommend that CMS provide a separate, longer opportunity for comment (e.g., at least 30 days) for organizations to provide feedback.

Section III – Part D

Payment for Hospice and ESRD Beneficiaries (page 126**)**

- **Proposed 2014 Hospice Drug Policy.** CMS is proposing that, beginning January 2014, when a sponsor receives a transaction reply report (TRR) showing a beneficiary has elected hospice the sponsor would place beneficiary-level Prior Authorization (PA) requirements on the following four categories of prescription drugs: analgesics, antinauseants (antiemetics), laxatives, and anxiety drugs. CMS indicates that this would be in lieu of the current practice of making conditional payment for drugs and biologics that may be covered under the Medicare Part A per-diem to a hospice program and having to recover payment if the drug was later determined to be the responsibility of the hospice facility. We agree that the current "pay-and-chase" approach is not efficient for a number of reasons, and that CMS' proposed approach to utilize beneficiary-level PA requirements is likely more practical. However, we have identified the following issues and related recommendations that we believe will assist CMS in refining the proposal, and we request that the agency consider them before moving forward with implementation.

    + *Notification of hospice enrollment.* We understand that there are concerns with relying on the TRR as a means to identify that an enrollee has elected hospice, which would be the trigger for implementing the PA requirement under the agency's proposal. Specifically, we understand that typically, there is a delay between when a beneficiary is enrolled in the hospice facility and when the plan is actually notified of the enrollment via the TRR, which would make it difficult to implement the proposed PA requirement in a timely manner. We believe the timing of the notification to plans must be improved before CMS moves forward with implementing the proposed policy, and we recommend that the agency evaluate potential strategies for doing so. For example, CMS could establish processes under which hospice providers would provide notification of enrollment within 3-5 days of admission, and where CMS would subsequently provide this information to plans on the weekly TRR. CMS also should provide the name of the hospice facility in which the beneficiary is residing and other relevant information to facilitate any subsequent contact that may be required.

    + *Beneficiary Notice.* CMS is seeking comment on whether there would be a benefit to sending a notice to the beneficiary once a claim has been rejected explaining the reason for the rejection. We do not believe that there would be value in sending a notice to the beneficiary in these instances. It is our understanding that the beneficiary would already receive the printed "Medicare Prescription Drug Coverage and Your Rights" notice that network pharmacy providers are required to furnish and provision of an additional notice could be confusing.

+ *Extending PA requirement to additional drug classes.* CMS also is seeking comment on whether the agency should extend the PA requirement to include drugs prescribed for chronic obstructive pulmonary disease (COPD) and 1 drug class for the 1 drug prescribed for amyotrophic lateral sclerosis (ALS). We recommend that CMS limit the policy to beneficiary-level PA requirements for the 4 categories of prescription drugs identified above and not expand the requirement to other drug categories at this time.

+ *LTC enrollees.* We recommend that CMS consider potential implications of the proposed policy on LTC enrollees and the potential role of LTC pharmacies in ensuring that these beneficiaries do not experience unintended interruptions in access to care.

Daily Cost-Sharing Requirements (page 129**)**

- **Daily Cost-Sharing Requirements for Prescriptions for Pain Medications.** The draft Call Letter reminds Part D sponsors of the requirement, beginning January 1, 2014 to establish and apply a daily cost-sharing rate to certain prescriptions dispensed by a network pharmacy for less than a 30-day's supply. We note that under §423.153(b)(4)(i)(B)(1) of the Part D regulations, solid oral doses of antibiotics are excluded from this requirement as they are typically written for a 10-day course of treatment. Our understanding is that similarly, prescriptions for short-term pain medications for the treatment of acute pain also are typically written for a 10-day course of treatment or less. We recommend that CMS consider excluding prescriptions for pain medications from the daily cost sharing requirement if the prescription is written for a 10-day or less supply because this practice is consistent with the practice standards for treating acute pain conditions. We believe extending the exclusion from this policy to these prescriptions will strike the appropriate balance between supporting the fraud, waste and abuse-related goals of the daily cost-sharing policy while preserving existing prescribing practices for clinically indicated courses of treatment in acute pain conditions.

Auto-Ship Refill Programs in Part D (page 133**)**

- **Beneficiary Consent.** CMS is proposing for CY 2014 for Part D sponsors to require their network retail and mail order pharmacies to obtain patient consent to deliver a prescription, new or refill, prior to each delivery. CMS is proposing this requirement because the agency believes that automatic delivery practices that pharmacies employ are potentially generating significant waste and unnecessary additional costs for beneficiaries and the Part D program overall. AHIP supports CMS' efforts to prevent and reduce fraud, waste, and abuse in the Part D program, and we recognize that an automatic refill or delivery service that is poorly structured could result in unintended waste and costs. However, we

believe that it is important ensure that fraud prevention efforts do not result in barriers that discourage beneficiary's from taking needed medications. We believe that when automatic refill or delivery services are appropriately structured, they have the potential to both provide value to beneficiaries as well as help achieve the agency's quality goals of improved medication adherence, safety, and safeguards against fraud and abuse. As a result, we believe that CMS should consider a policy that preserves the benefits of these services by drawing upon best practices while dissuading the potentially wasteful practices the agency has highlighted. We would welcome the opportunity to work with the agency to identify strategies that meet these goals.

Applicability of Rewards and Incentives in Part D (page 135**)**

- **Rewards and Incentives.** CMS is soliciting comments from Part D sponsors to help the agency better understand if guidance on rewards and incentives for the Part D program would be beneficial, and if so, the types and levels of rewards or incentives sponsors would propose to offer enrollees. As also noted in our Part C comments, AHIP member organizations have a strong interest in exploring these opportunities, and we commend CMS for inviting feedback on these important topics. We reiterate our comment that the current brief comment period does not offer sufficient opportunity to prepare relevant information for submission due to the number and scope of issues addressed by the Advance Notice and draft Call Letter. We recommend that CMS provide a separate, longer comment period (e.g., 60 days) for organizations to share the requested information. We encourage CMS to continue pursue these issues and look forward to commenting in the near future.

Million Hearts™ Initiatives (page 137**)**

- **Medication Therapy Management (MTM) Services.** Consistent with the goals of CMS' Million Hearts™ Initiative, the agency is proposing to encourage sponsors to offer Medication Therapy Management (MTM) to beneficiaries who fill one or more prescriptions for anti-hypertensive medications in an effort to improve access and adherence to these drugs. CMS notes that "this would not result in additional payment under Medicare Part D." It is our understanding that targeting beneficiaries who are identified solely on the basis of prescribed anti-hypertensive medications could significantly increase the number of individuals enrolled in sponsor MTM programs and strain the resources available to provide these services to beneficiaries who would be likely to receive much greater benefit from these programs. While we are supportive of the goals of the Million Hearts™ Initiative, we recommend that the proposed requirement should be reconsidered.

Part D Benefit Parameters for Non-Defined Standard Plans (page 141)

- **Minimum Monthly Cost-Sharing OOPC Difference Between Enhanced Plan Offerings.** For CY 2014, CMS is proposing that the minimum monthly cost-sharing Out-of-Pocket Cost (OOPC) difference between enhanced plan offerings will be $18, which is an increase from the $12 OOPC difference amount required for CY 2013. The agency's intent for the OOPC differential requirement is to reduce beneficiary confusion by requiring that when sponsors offer multiple plans they must be meaningfully different r. However, we believe the proposed change to OOPC values will result in changes to enhanced plans for 2014 that will disadvantage beneficiaries who are currently enrolled in the plan with higher OOPC values. We recommend that CMS decrease the proposed OOPC difference to be more consistent with the 2013 amount.

- **Proposed Change to OOPC Calculation for CY 2015.** CMS is considering a possible change to the methodology for the Out-of-Pocket Cost (OOPC) calculation for CY 2015 specifically related to the estimation of non-formulary drug costs in the model. Specifically, CMS is proposing that non-formulary drugs would be priced at the cost-sharing of the Part D sponsor's exceptions tier. The agency expects that this proposed change, which is based on the assumption that in most cases sponsors will provide a formulary exception for non-formulary drugs, will provide a more accurate reflection of the estimated OOPC. The proposal to include non-formulary drugs at the non-preferred brand co-pay tier will result in the formulary having a much smaller impact on OOPC differential and making dissimilar plans appear to be similar. However, for a beneficiary taking a non-preferred brand a plan that does not include the drug on the formulary is significantly different than one that includes the drug in a non-preferred status. For this reason we recommend that CMS not move forward with the proposal.